

PATIENT INFORMATION FORM



Check one of the following:

Attach copy of front and back of Insurance card

All CIGNA Insurance

Other Insurance (Any Non-CIGNA)

FFS/Self Pay

PATIENT INFORMATION

1

| | | | | | | | |
|---------------------------------------|--|-------------------------------|-------|---------------|-------------------------|-----|--|
| LAST NAME, FIRST NAME, MIDDLE INFTIAL | | SOCIAL SECURITY # | | DATE OF BIRTH | | SEX | |
| | | | | | | M F | |
| STREET ADDRESS | | CITY | STATE | ZIP CODE | PATIENT PHONE | | |
| RESPONSIBLE PARTY | | RELATION TO RESPONSIBLE PARTY | | | | | |
| RESPONSIBLE PARTY STREET ADDRESS | | CITY | STATE | ZIP CODE | RESPONSIBLE PARTY PHONE | | |

INSURANCE COVERAGE/OWNER OF INSURANCE POLICY

2

| | | | | | | | |
|-----------------------|--|-------|---------------------|-------|-------------------|---------|-------------------------|
| LAST NAME | | FIRST | M.I. | DOB | SOCIAL SECURITY # | | RELATIONSHIP TO PATIENT |
| STREET ADDRESS | | CITY | | STATE | ZIP | | |
| EMPLOYER | EMPLOYER ADDRESS (STREET, CITY, STATE, ZIP CODE) | | | | | | |
| WORK PHONE () | HOME PHONE () | | INSURANCE CARRIER* | | | | |
| INSURANCE CO. ADDRESS | | | INSURANCE CO. PHONE | | POLICY / ID # | GROUP # | |

Is the patient covered under any other health coverage? Yes No If yes, complete Additional Healthcare Insurance. (Sec. 3)

ADDITIONAL HEALTHCARE INSURANCE (Medicare Part B - FFS, Supplemental, All Other Insurance)

3

| | | | | | | | |
|-----------------------|--|-------|---------------------|-------|-------------------|---------|-------------------------|
| LAST NAME | | FIRST | M.I. | DOB | SOCIAL SECURITY # | | RELATIONSHIP TO PATIENT |
| STREET ADDRESS | | CITY | | STATE | ZIP | | |
| EMPLOYER | EMPLOYER ADDRESS (STREET, CITY, STATE, ZIP CODE) | | | | | | |
| WORK PHONE () | HOME PHONE () | | INSURANCE CARRIER* | | | | |
| INSURANCE CO. ADDRESS | | | INSURANCE CO. PHONE | | POLICY / ID # | GROUP # | |

IN CASE OF EMERGENCY CONTACT

4

| | | | | |
|-----------|--|-------|------|-------------|
| LAST NAME | | FIRST | M.I. | TELEPHONE # |
|-----------|--|-------|------|-------------|

Your signature below indicates:

- (If you have insurance) You authorize CIGNA Medical Group (CMG) to release medical or other information as requested by your insurance company to have your medical claims paid.
- (If you have insurance) You authorize direct payment of medical benefits by your insurance company to CMG for any services furnished to you and otherwise payable to you.
- Your agreement to pay any and all final balance due to CMG for services you receive which are your responsibility and/or are denied by your insurance company.

5

Patient/Parent or Legal Guardian Signature **MUST BE SIGNED/ DATED**

Date

SP1932 Rev. 10/2003

White Copy - Medical Record
(Front of Data Base)

• Canary Copy - Finance

Return Completed PIF to the Front Office